NAME OF PROVIDER OR SUPPLIER HIRAM W DAVIS MEDICAL CTR SUMMARY STATEMENT OF DEFICIENCIES TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS F 000 INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid abbreviated survey was conducted 10/15/19 through 10/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 90 certified bed facility was 48 at the time of the survey. The survey sample consisted of 5 resident reviews. F 558 Services Provided Meet Professional Standards SSSED CFR(s): 483.21(b)(3)(i) \$483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to follow standards of quality for one resident #2 was survey sample of 5 Residents. Resident #2 was survey sample of 5 Residents are survey sample of 5 Residents and survey sample of 5 Residents. Resident #2 was survey sample of 5 Residents reviews. All residents have the execution to the sample state of the sample s	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495113		(X2) MUL A. BUILD	TIPLE CON	STRUCTION	FORM APPROV OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED		
HIRAM W DAVIS MEDICAL CTR STREET ADDRESS, CITY, STATE, ZIP CODE 26317 WEST WASHINGTON STREET PETERSBURG, VA 23803 PROVIDER'S PLAN OF CORRECTION ECACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 10/15/19 through 10/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 90 certified bed facility was 48 at the time of the survey. The survey sample consisted of 5 resident reviews. F 658 SS=D CFR(s): 483.21(b)(3)(i) § 483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to follow standards of quality for one resident (#2) in a survey sample of 5 Residents. Resident #2 was survey sample of 5 Residents page to the page of the same deficient practice.			B. WING		C			
PETERSBURG, VA 23803 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) F 000 INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 10/15/19 through 10/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 90 certified bed facility was 48 at the time of the survey. The survey sample consisted of 5 resident reviews. Services Provided Meet Professional Standards F 658 SS=D CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to follow standards of quality for one resident (#2) in a survey sample of 5 Residents. Resident #2 was survey sample of 5 Residents.	NAME OF PROVIDER OR SUPPLIER				STREET	EST WASHINGTON STREET	10/16/201	
An unannounced Medicare/Medicaid abbreviated survey was conducted 10/15/19 through 10/16/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey. The census in this 90 certified bed facility was 48 at the time of the survey. The survey sample consisted of 5 resident reviews. Services Provided Meet Professional Standards SESED CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on facility documentation and clinical record review and in the course of a complaint investigation, the facility staff failed to follow standards of quality for one resident (#2) in a survey sample of 5 Residents. Resident #2 was	PREFIX TAG	REGULATORY OR L	T MOST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	PETER	PROVIDER'S PLAN OF CORRECTIVE ACTION SHORTS REFERENCED TO THE APPLICATION SHORTS ROSS-REFERENCED TO THE APPLICATION SHORTS ROSS-REFERENCED TO THE APPLICATION SHORTS ROSS-REFERENCED TO THE APPLICATION OF THE PROPERTY OF T		
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not served the correct meal tray which had food specifically prepared to meet his medical needs. The findings included: Resident #2 a 58 year old man was admitted to the facility on 5/28/15 with diagnoses of but not limited to dysphagia, history of recurrent aspiration pneumonia, seizure disorder, schizophrenia, hypothermia, bradycardia, spinal stenosis, DJD (Degenerative Joint Disease) to	= 658 SS=D	consisted of 5 resided Services Provided M CFR(s): 483.21(b)(3) Services provided as 21(b)(3) The services provided as outlined by the commustiful Meet professional This REQUIREMENT by: Based on facility documents as a consideration of the facility for the facility for the facility for the facility prepared of the findings included the facility on 5/28/15	vey. The survey sample nt reviews. eet Professional Standards (i) ehensive Care Plans d or arranged by the facility, mprehensive care plan, standards of quality. is not met as evidenced umentation and clinical the course of a complaint ity staff failed to follow or one resident (#2) in a residents. Resident #2 was a meal tray which had food to meet his medical needs. Told man was admitted to with diagnoses of but not		2.	Address what measures will or systemic changes made t deficient practice will not red	idents found to eficient practice. with the deficient ober 4, 2019 on ring the resident is ited on the I identify other ial to be affected by all to be at risk for not tray. I be put into place to ensure that the cur.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 10/30/2019 ED

CENTE	RS FOR MEDICAR	RE & MEDICAID SERVICES					FORM APPROVE
1 SIMIEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONS	STRUCTION	OMB NO. 0938-039
100		IDENTIFICATION NUMBER:	A. BUILDI				(X3) DATE SURVEY COMPLETED
NAME OF		495113	B. WING				С
NAME OF	PROVIDER OR SUPPLIEF	₹		STD	EET /	ADDDEGG	10/16/2019
HIRAM	N DAVIS MEDICAL C	ть		363	CE /	ADDRESS, CITY, STATE, ZIP CODE	
				203 DE1	IF VY	EST WASHINGTON STREET	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		FEI	ERS	SBURG, VA 23803	
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F 658	Continued From pa	ane 1	1	1			
	disorder unspecifie	age i	F 65	8	4.	THE PARTY OF THE P	ns to monitor its
						sustained.	hat solutions are
į	set) with APD (and	recent MDS (minimum data				A meal observation tool will be	implemented to
!	AND MICH WITH CASSE	assmont rotoron				crisure stail compliance with for	Mowing the mool
	the Resident as have	n annual assessment, codes ving a (Brief Interview of				caru, ensuring the resident is c	liven the correct
	THE PROPERTY OF THE PROPERTY O	S SCORO OF D : I'- I'				meal tray listed on the Compre	hensive Care plan.
	LIGHT STATE OF THE PROPERTY OF	Or linable to commit			5.		
	TO THE THE STATE OF THE STATE O	1 AS ITTI I OTOL ASSOCIATION			Si	Include dates when the correction	ective action will be
	THE THE PERSON AND THE	ISON DOVERSAL SOCIAL				November 30, 2019	
	CHOCKING, DARRING (1	receing and then a					
	STORESTON AND MUDE	of Chair and fan and					
(#2) 1 person physic	sive Assistance and requiring					
:							
. (On 10/15/19 during o	clinical record review it was					
; ~	ing of the first out	U/4/19 the Resident had					
, 1	eceived a meal trav	With a regular diet when he					
8.	ing orders in CHODD	180 GIST With thickened					
h	quids. The resident	subsequently choked and					
h	im,	nlich maneuver performed on					
2.5.5							
E	xcerpts from the FF	RI (facility reported incident)					
	Juu.						
i "I	Results of the invest	tigation showed that the					
re	esident received a re	egular diet that staff cut up					
; Ir	ito pieces, instead o	of the chopped diet that was					
0	rdered. The facility	kitchen sent the correct diet					
ito	or that meal, but the	staff assisting the resident					
W	ith that meal admitte	ed to mistakenly giving the					
re	esident a regular die	t tray instead."					
0	n 10/16/19 at appro	eximately 10:00 AM the DON					
p	rovided a copy of a	document titled "Clinical					
P	rocedure 152-A Res	sident / Patient dining."					

Excerpts from the document state:



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/30/2019 FORM APPROVED

NAME OF PROVIDER OR SUPPLIER HIRAM W DAVIS MEDICAL CTR			(X2) MULT A BUILDII B WING		(X3) DATE SURVEY COMPLETED C 10/16/2019	
				STREET ADDRESS, CITY, STATE, ZIP CODE 26317 WEST WASHINGTON STREET PETERSBURG, VA 23803		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES H DEFICIENCY MUST BE PRECEDED BY FULL LATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		

F 658 Continued From page 2

"IV- 1. Dining

Each resident/patient will have an individualized meal card.

- a) Staff making sure they are following the instructions on the resident's meal card
- b) Ensuring residents are given the correct diet
- c) Double checking the meal tickets against the meal cards prior to serving the residents and not modifying any diet."
- All staff will follow the "Five Rights" of meal service assistance:
 - *Right Resident
 - *Right Diet
- *Right Consistency including not modifying food texture
 - *Right Level of Supervision or Assistance
- *Right Equipment to Include Adaptive Equipment and Dentures.

The employee received an "Employee Counseling Report" that read: "Reason for conference:

On 10/4/19, you inadvertently gave a patient the incorrect tray. This lack of oversight is potentially detrimental to the patient's wellbeing, as in addition to choking, consuming the incorrect meal

consistency can be fatal to the patient."

"Corrective actions to be taken by employee: When offering nutrition to patients please review meal card to ensure the correct diet consistency and precautions are being followed. Additionally double check the meal tickets against the meal card before offering the meal to the patient. If there are any concerns, please report to the nurse and or speech therapist for follow up."

F 658



DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 10/30/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A BUILDING_ COMPLETED 495113 B WING NAME OF PROVIDER OR SUPPLIER 10/16/2019 STREET ADDRESS, CITY, STATE, ZIP CODE HIRAM W DAVIS MEDICAL CTR 26317 WEST WASHINGTON STREET PETERSBURG, VA 23803 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE (X51 COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 658 Continued From page 3 F 658 "Employee Comments: "I not double checking | mistakenly gave the wrong tray which resulted in the incident which I very sorry for [sic]. I've been re-in serviced and am aware of protocol." On 10/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided. F 689 Free of Accident Hazards/Supervision/Devices 1. Address how corrective action will be SS=D CFR(s): 483.25(d)(1)(2) F 689 accomplished for those residents found to have been affected by the deficient practice. §483.25(d) Accidents. The Certified Nursing Assistant with the deficient The facility must ensure that -§483.25(d)(1) The resident environment remains practice was educated on October 4, 2019 on not as free of accident hazards as is possible; and modifying a regular tray to chopped to prevent accidents. §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent Address how the facility will identify other accidents residents having the potential to be affected by This REQUIREMENT is not met as evidenced by: the same deficient practice. Based on staff interview, facility documentation All residents have the potential to be at risk for and clinical record review and in the course of a accidents from altering meal trays. complaint investigation, the facility staff failed to ensure the Residents are free from accident and Address what measures will be put into place or hazarads for 1 Resident (#2) was free from systemic changes made to ensure that the accident hazards. deficient practice will not recur.

Findings included:

For Resident #2 the facility staff accidentally gave the Resident the wrong tray which resulted in a choking incident requiring the Heimlich maneuver.

Resident #2 a 58 year old man was admitted to the facility on 5/28/15 with diagnoses of but not limited to dysphagia, history of recurrent All direct care staff will be in-serviced on not modifying any diet to prevent accidents.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

A meal observation tool will be implemented to ensure staff compliance with not modifying any diet to prevent accidents.

DEPARTMENT OF HEALTH AND HUMAN CEDUIC

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CENTE	ERS FOR MEDICAR	E & MEDICAID SERVICES				FORM APPROVE
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIP		STRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
WANE OF		495113	B. WING			С
	F PROVIDER OR SUPPLIER W DAVIS MEDICAL CT			26317 WE	ADDRESS, CITY, STATE, ZIP CODE VEST WASHINGTON STREET SBURG, VA 23803	10/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPRO DEFICIENCY)	II D DE
F 689	aspiration pneumon schizophrenia, hypo stenosis, DJD (Dege	nia, seizure disorder, othermia, bradycardia, spinal generative Joint Disease) to k), g-tube and conduct	F 689	5.		ctive action will
: (7/25/19 coded as an the Resident as havi Mental Status) BIMS Resident is unwilling Resident was coded requiring (#3) 2+ personal toileting. Bathing, dreambulation via wheel coded as (#3) Extens (#2) 1 person physical					
r h li	received a meal tray whas orders for choppe liquids. The resident	clinical record review it was 0/4/19 the Resident had with a regular diet when he ped diet with thickened t subsequently choked and mlich maneuver performed on				
E	Excerpts from the FR read:	RI (facility reported incident)				
ro ir o fo	resident received a re into pieces, instead of ordered. The facility ke for that meal, but the se	tigation showed that the egular diet that staff cut up of the chopped diet that was kitchen sent the correct diet e staff assisting the resident red to mistakenly giving the				

resident a regular diet tray instead."

On 10/15/19 at approximately 4:00 PM an



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	ERS FOR MEDICA	RE & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495113	B. WING		С	
NAME OF PROVIDER OR SUPPLIER HIRAM W DAVIS MEDICAL CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 26317 WEST WASHINGTON STREET PETERSBURG, VA 23803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE	
F 689	F 689 Continued From page 5 interview was conducted with employee G (Dietary Manager) who stated that in the kitchen they have a double check system for the meal			689		

When asked about the chopped diet he stated that in a chopped diet the food is cut 1/2" X 1/2" cubes, the ground diet is 1/4" X 1/4" cubes.

that the meal is correct."

trays. The tickets are on the tray the food gets placed on the tray according to the tickets and We have kitchen supervisors who do nothing but check the trays as they come off the line to see

On 10/16/19 at approximately 3:00 PM in an interview with employee F (Speech Language Pathologist) she stated that she was on the floor the day of the incident and remembers the Resident got an alternate tray instead of his chopped diet try by accident. She further elaborated that when she found out what was going on she looked at the tray and "I realized the problem right away because I was feeding someone with a chopped diet and it was chopped beef patty with gravy and [Resident #2] had a grilled chicken sandwich cut up on his tray."

Employee F stated that a chopped diet from the kitchen is cut up to specific size pieces. With the staff cutting the food there was no way to tell what size the pieces were. She also stated that the kitchen tends to send food that is moister or has gravy or sauce to keep it from drying out. The chicken sandwich was grilled chicken on a bun with lettuce and tomato.

On 10/16/19 during the end of day meeting the Administrator was made aware of the findings and no further information was provided.

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